

**UNIVERSITY OF NORTH TEXAS HEALTH SCIENCE CENTER  
AT FORT WORTH  
SICK LEAVE POOL DONATION/REQUEST FORM**

Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Department \_\_\_\_\_ Phone # \_\_\_\_\_

Job Title \_\_\_\_\_

**DONATION:** I wish to contribute \_\_\_\_\_ # hours of sick leave time to the Sick Leave Pool.

Note: Active (Benefits Eligible) employees may donate sick leave to the Pool in increments of eight hours. Regular part-time active employees may donate sick leave in increments equal to their percentage of time employed times eight hours.

In making this donation I understand that it is:

- \* Strictly voluntary,
- \* For use by any eligible employee and I may not stipulate who may receive this donation and,
- \* No longer my property right and that my sick leave balance will be reduced by a corresponding amount.

Employee Signature \_\_\_\_\_ Date \_\_\_\_\_

**WITHDRAWAL:** I am requesting time from the Sick Leave Pool.\* I understand that I must meet the following conditions:

1. I have or a member of my immediate family has suffered a catastrophic illness or injury. It is a severe condition affecting my mental or physical health or that of my immediate family member and,
2. My absence is expected to be 45 calendar days or longer and,
3. I will have exhausted all leave entitlement and,
4. I have attached a statement from a licensed practitioner supporting statements 1 and 2.

This is a request for (check one):

\_\_\_\_ Sick Leave Pool time due to catastrophic illness/injury incurred by employee  
\_\_\_\_ Sick Leave Pool time due to catastrophic illness/injury incurred by a member of my immediate family.  
Name of Family Member \_\_\_\_\_ Relationship \_\_\_\_\_  
List the type of care you will provide for the family member:

What alternative sources of care are available for the patient (home health care, visiting nurse, another relative, etc.)?

First day unable to work because of illness/injury \_\_\_\_\_

Date all paid leave exhausted \_\_\_\_\_

Date you will return to work \_\_\_\_\_

\_\_\_\_\_  
Signature of Employee                      Date

\_\_\_\_\_  
Department Chairperson                      Date  
(Your signature indicates that you have been notified of this leave request. It does not indicate your approval.)

\_\_\_\_\_  
Sick Leave Pool Administrator  
Hours Approved \_\_\_\_\_ Comments:

\_\_\_\_\_  
Date Received by Administrator

\* If it is determined at a later date that you were ineligible to receive benefits from the Sick Leave Pool, the benefits paid to you must be repaid to the Pool.